Long Term Care

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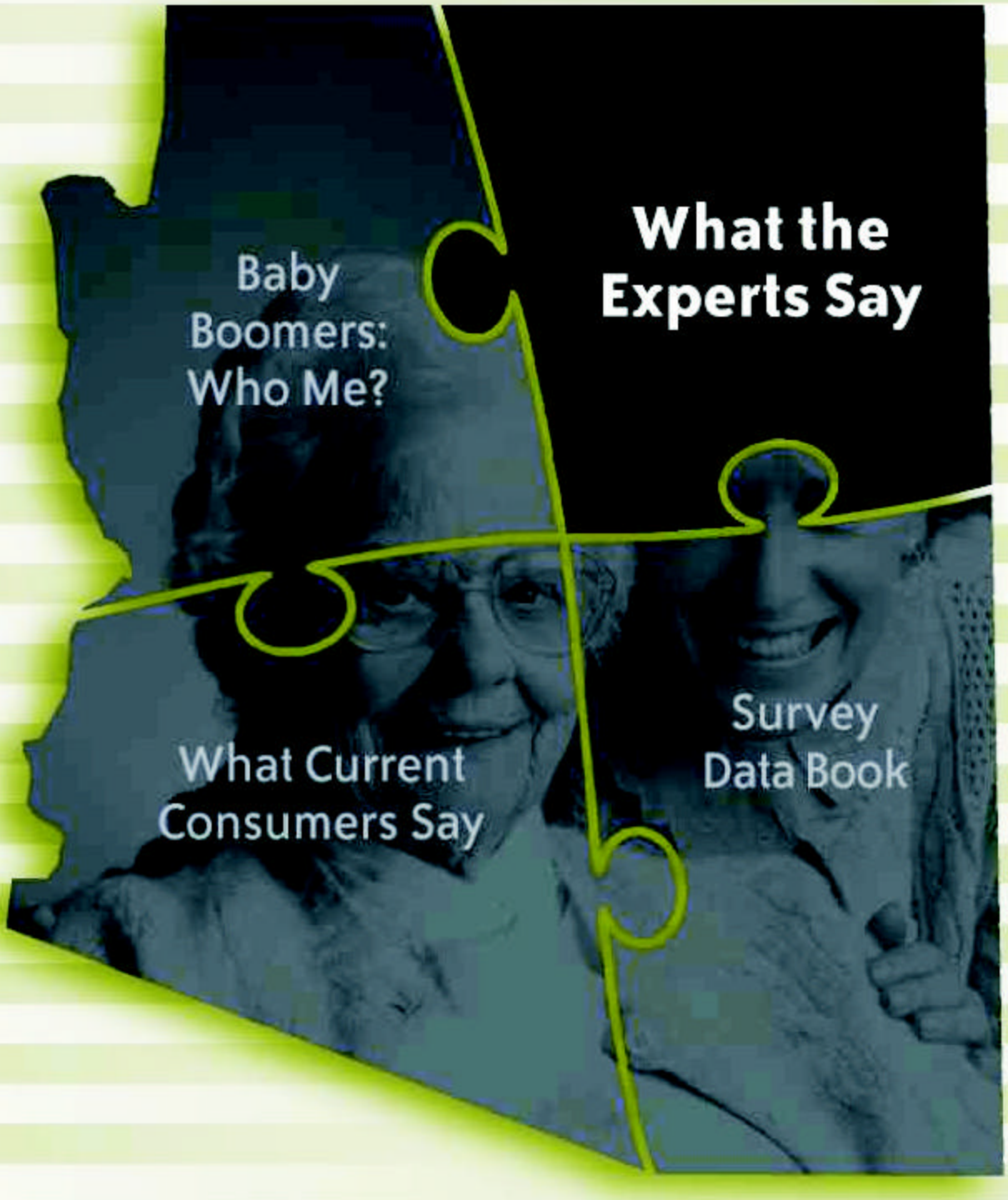

ARIZONA LONG TERM CARE SYSTEM (ALTCS)
IN MARICOPA COUNTY

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Summary

The intent of the literature review for the AHCCCS Long Term Care Consumer Satisfaction Survey Project is to provide a synthesis of information regarding existing consumer satisfaction surveys pertaining primarily to the aging population, long term care, and satisfaction with health care. The literature review also laid the foundation for the design and development of the long term care consumer satisfaction survey.

Over the years, many research organizations, including health care providers, have attempted to identify the factors surrounding the measurement of consumer satisfaction with health care services. The introduction of consumer satisfaction partly occurred because health care providers, on a nationwide basis, found themselves accountable to consumers in ways other than those that normally function in the market. The primary measure typically was centered around a consumer's clinical assessment. However, with the introduction of consumer satisfaction a shift occurred whereby clinical assessment would be augmented by the humanness of care delivered by the health care system and the providers. Thus, numerous organizations and researchers came together to create new tools to assist in measuring consumer's satisfaction.

A review of the literature on consumer satisfaction with health care services, specifically for those in long term care, was very weak. This was especially true for a statewide LTC, managed care environment that provides the entire array of services (e.g., LTC, medical behavioral health and case management). However, the research team was able to locate studies and instruments dealing with consumer satisfaction with health care services on a generic level. As previously indicated, the concept of "consumer satisfaction" has been growing and, as such, these generic studies assisted the research team in determining what domains of care should be considered for measurement, as well as the selection of "wording" and "scaling" for the survey. More importantly, the research team was able to locate local instruments utilized by long term care agencies that further identified domains of care for consideration.

The articles, which have been included in the Literature Review Book were used by the Research Team to assist in the development of the Consumer Satisfaction Survey. However, as one might expect, there were many additional articles that were read and reviewed by the researcher and not included in this book because they were not applicable to the development of the studies survey. For example, the criteria established for an article to be included in this book was either its direct applicability on study methodology (e.g. studies that involved long term care populations in both home and community based settings and nursing facilities) or survey questions (e.g. consumer satisfaction with health care services). As such, the literature review book is divided into four sections.

The first section deals with the four survey instruments that the research team primarily relied upon to guide the development of its long term care consumer satisfaction survey. These instruments include the (1) Department of Economic Security (DES) Non-Medical Home and Community-Based Services – Customer Satisfaction Survey (March 1999), (2) 1999 Maricopa Integrated Long Term Care Nursing Home Client Survey, (3) the Consumer Assessment of Health Plans Study (Version 2.0H), and (4) the Development and Validation of Scales to Measure Patient Satisfaction with Health Care Services: Volume I. Part A. Review of Literature,

Overview of Methods, and Results from Construction of Scales (PSQ). An additional study included in this section includes self-rated health.

The second section of the literature review book presents studies dealing with long term care and long term care facilities. The third section presents studies dealing with elderly populations, and the fourth sections present studies dealing with patient (consumer) satisfaction. Finally, there are a number of survey items that were written and designed by the research team. These "original" questions are based, in some way, on the readings of the literature and the background of the research team.

SECTION I. PRIMARY RESEARCH INSTRUMENTS

DES NON-MEDICAL HOME AND COMMUNITY-BASED SERVICES – CUSTOMER SATISFACTION SURVEY (MARCH 1999)

Author: Prepared by the Department of Economic Security, Arizona Aging and Adult Administration.

Background*:* In February 1999, the DES Field Operations Unit of the Arizona Aging and Adult Administration developed two surveys to measure past and current client satisfaction with the Non-Medical Home and Community-Based Services (NMHCBS). The purpose of collecting survey data was to indicate the level of client determination that the provision of NMHCBS allowed clients to remain independent and avoid premature institutionalization.

Study Measures: The first survey was distributed to clients currently receiving services and the second survey was distributed to former clients. The surveys were identical except for a series of added questions to former clients. There were four sections to the survey. The first section collected demographic information on clients and also requested the type of services provided to the client. The second section addressed client centered questions. The third section asked clients their perception of their life at the present time. The fourth section asked clients to offer comments on how the program could be improved.

Population/Demographics: A random, stratified sample was used for this project. A total of 492 completed surveys, with a return rate of 29%, were returned. Three hundred ninety-four (394) surveys were from current clients and 98 surveys were from past clients. For current clients, the majority (83.3%) was female with the majority of clients falling in the 70-79 age group. For past clients, the majority (78.6%) was female with the majority of clients falling into the 70-79 age group.

Findings: Nearly 43% of the clients surveyed rated the overall quality of the help they received as excellent. Clients (68.7%) also indicated that the services provided helped them to retain their independence and remain in their home. Clients (68.4%) also felt that they had control over their lives.

1999 MARICOPA INTEGRATED HEALTH SYSTEMS LONG TERM CARE NURSING HOME CLIENT SURVEY

Maricopa Integrated Health Systems, Maricopa County Research and Reporting Unit.

Background: Maricopa County, Office of Research and Reporting, located in Phoenix, Arizona developed a survey to determine how satisfied clients are with the Maricopa County Long Term Care Plan. The purpose of the study was to determine client satisfaction with services and identify areas for improvement. Maricopa County talked with family members or close friends of nursing home clients to ascertain the level of satisfaction for clients who could not speak on their own behalf. Types of services addressed included attendant care and adult foster care.

Study Measures: Several study measures were used to determine the level of satisfaction among both clients and proxies (family members and close friends). The study measures were:

- Satisfaction with Case Managers
    - Accessing the case manager
    - Explanation of programs and/or services by the case manager
    - Overall satisfaction
- Satisfaction with Primary Care Providers (Doctors)
    - Accessing the doctor
    - Responsiveness by the doctor and/or his staff
    - Overall satisfaction
- Satisfaction with Maricopa Medical Center
    - Emergency Room Services
    - Outpatient Medical Care Clinics/Specialty Clinics
    - Inpatient Services
- Satisfaction with Family Health Centers
    - Courtesy and Respect
    - Privacy
    - Scheduling Appointments
    - Waiting time to see Family Health Center provider
    - Prescription Services
    - Laboratory
    - Quality of medical care
- Satisfaction with Nursing Staff
    - Accessing the nursing staff
    - Courtesy and Respect
    - Responsiveness
    - Overall satisfaction
- Satisfaction with Maricopa County Long Term Care Plan
    - Complaints
    - Handling of Complaint by System
    - Overall Satisfaction

National Committee on Quality Assurance.

In October 1995, the Agency for Health Care Policy and Research (AHCPR), one of the agencies of the Federal Public Health Service, announced that it was launching a new project that would build an "integrated set of carefully tested and standardized questionnaires and reporting formats that could be used to collect and report meaningful and reliable information about the experiences of consumers enrolled in health plans." Several agencies and organizations joined with AHCPR to form a consortia to work collaboratively on the development of the questionnaire. Members of the consortia included Harvard Medical School, Research Triangle Institute, RAND, and Westat. AHCPR, along with the Health Care Financing Administration (HCFA) continue to support and participate in the development of these questionnaires.

One of the most prominent organizations that evaluates and reports on the quality of managed care health plans is the National Committee for Quality Assurance (NCQA). It carries out this work both prospectively, through its standards for the accreditation of managed care organizations, and retrospectively, through its Health Plan Employer Data and Information Set (HEDIS) health plan quality performance measures. In 1991, NCQA included in HEDIS a consumer satisfaction survey called the Member Satisfaction Survey.

CAHPS 1.0 (Consumer Assessment of Health Plans Study) and NCQA's Member Satisfaction Survey had several significant differences in content, approach, and protocol requirements. In 1998, therefore, the CAHPS development team and NCQA agreed to converge the two surveys into a common survey that would use superior components from both surveys; incorporate the perspectives and needs of consumers, purchasers, and health plans; and serve the purposes of NCQA and CAHPS sponsors. This resulted in a single core CAHPS 2.0 survey that performs the following:

- Assesses all health care systems (fee-for-service and managed care);
- Applies across Medicare, Commercial, and Medicaid populations;
- Gathers quality improvement information; and
- Enhances comparative information on health care quality.

The CAHPS 2.0 questionnaires consisting of the core and HEDIS supplemental set when used by health plans for HEDIS reporting or NCQA accreditation is referred to as CAHPS 2.0H. When it is not used for reporting to NCQA, it is called CAHPS 2.0. There are some differences between the two surveys, although they are largely the same.

The CAHPS 2.0H surveys are a set of standardized surveys that assess patient satisfaction with the experience of care. The survey is based on a randomly selected sample of members from the Managed Care Organization and summarizes satisfaction with the experience of care through ratings and composites. Four global rating questions reflect overall satisfaction.

- Rating of all health care

- Rating of health plan
- Rating of personal doctor
- Rating of specialist seen most often.

Six composite scores summarize responses in key areas:

- Claims processing
- Courteous and helpful office staff
- Customer service
- Getting care quickly
- Getting needed care
- How well doctors communicate

The overarching goal of the CAHPS 2.0H surveys is to effectively obtain from Managed Care Organization members or the person receiving care information that is not available from any other source. This survey instrument can be used across health care systems to capture experiences from all health care consumers. The instrument builds on the HEDIS 3.0 Member Satisfaction Survey and previous versions of the CAHPS survey.

For the purposes of the literature review that supported the design of the long term care consumer satisfaction survey , the research team utilized the following domains from the CAHPS 2.0H:

- Rating of personal doctor
- Courteous and helpful office staff
- How well doctors communicate

DEVELOPMENT AND VALIDATION OF SCALES TO MEASURE PATIENT SATISFACTION WITH HEALTH CARE SERVICES: VOLUME I. PART A. REVIEW OF LITERATURE, OVERVIEW OF METHODS, AND RESULTS FROM CONSTRUCTION OF SCALES – PATIENT SATISFACTION QUESTIONNAIRE (PSQ)

John E. Ware, Jr., Mary K. Snyder, and W. Russell Wright.

Performing Organization: Southern Illinois University, School of Medicine, Carbondale, Illinois. Reproduced by the U.S. Department of Commerce, National Technical Information Service. (Report Date: 1976).

Background: Some of the more important issues involved in the conceptualization and measurement of patient satisfaction with health care services that remained unresolved in 1972 included the following:

a. What proportion of people (both current and potential patients) are dissatisfied with health care services?
b. What is the dimensionality of patient satisfaction with health care services?
c. Do satisfaction surveys measure anything?
d. What do satisfaction scores mean, i.e., how should they be interpreted and used?
e. Is satisfaction a dichotomy (i.e., are persons either satisfied or dissatisfied), or can persons be reliably placed along a continuum of satisfaction with care?
f. How long does it take to gather satisfaction data, and what are the tradeoffs involved in choosing among the various data-gathering methods described in the literature?
g. How should the content of patient satisfaction questionnaires (constructed for general use) be determined?

The review of the literature was focused on the following general questions:

1. What has been the content of questionnaires used to survey how patients feel about health care?
2. What have satisfaction questionnaires been used for?
3. What levels of enumeration (nominal, ordinal, interval, ratio) have been achieved or assumed in scoring questionnaire responses?
4. Which scaling techniques have been successfully used to construct satisfaction scales?
5. What information is available regarding the reliability of patient satisfaction scores?
6. What information is available regarding the validity of patient satisfaction scores?
7. What information is available regarding the relationships between demographic and socioeconomic variables and patient satisfaction scores?

Upon completion of the literature review process, items had been assigned to the following categories and subcategories:

1. Accessibility of care
2. Availability
    a. Of particular doctor
    b. Doctors in general
    c. Of services
3. Continuity of care
4. Convenience of services
5. Cost of services
6. General satisfaction
7. Humaneness of providers
    a. Doctor-patient communication
    b. Responses to patients
    c. Doctor's image
    d. Staff
    e. Physical surroundings
8. Quality of care
9. Care of the poor
10. Miscellaneous
11. Eliminated items

On the strength of the findings regarding the reliability and validity of scales constructed from the Southernmost Illinois Study questionnaires and our familiarity with the literature on the conceptualization and measurement of satisfaction with health care services, a new satisfaction questionnaire was constructed in 1972. Eighty items, each in the form of a complete statement of opinion, were included in Form I of the PSQ and the questionnaire was administered to participants in the Tri-County Study. A Likert Scale was used to score the questionnaire – Strongly Agree = 5, Agree = 4, Uncertain = 3, Disagree = 2, and Strongly Disagree = 1. Two short forms of the PSQ have been developed.

SELF-RATED HEALTH (SRH)

Beaton Sarah R. and Voge Susan A. (1998). *Measurements for Long Term Care*. California: SAGE Publishing, Inc. (page 151).

Description: Perceived health status, or self-ratings of health, has a "unique, predictive, and thus far inexplicable relationship with mortality". They have been seen as "useful proxies" for clinically measured health status and as determinants of post-illness adjustment. A single global measure self-related health (SPH), is easy and inexpensive to obtain. This measure has been proposed as a way to identify persons at increased risk for hospital admission or nursing home placement.

Psychometric Properties: Generally, moderate but significant correlations have been found between perceived health and findings on physical examination and physician ratings. Several studies with large U.S. and Canadian samples have shown that the way individuals view their health is related to subsequent health outcomes analyzed by cross-sectional data gathered in a population survey conducted by the U.S. Census Bureau. In addition to SRH, the respondents, who were over 65 years old, provided "objective" health data by completing a disability scale and indicating their illnesses or physiological disorders on a checklist. Results showed that both age and gender variables were important when considering SRH: An "old-old" (75 and older) person with "excellent" SRH reported the same level of disability as the merely "old" (65-74) whose health had been rated "good. Males had a tendency to rate themselves as having poorer health, even though they reported fewer illnesses and disabilities. Men and women with poor ratings had a 2.33 and a 5.10 greater mortality risk, respectively.

Procedure: The question to generate a self-rating of health has been asked in slightly different ways by different investigators. The following are three examples.

1. "Compared to others your own age, how do you rate your health?" (Mossey & Shapiro, 1982, p. 800)
2. "All in all, would you say that your health is excellent, good, fair, or poor?" (Kaplan & Camacho, 1983, p. 294)
3. "Generally speaking, would you describe your present health as excellent (1), good 92), fair (3), or poor (4)?" (Ferraro, 1980, p. 378).

Scoring: Just as questions varied, investigators have used different scoring systems for SRH.

SECTION II. LONG TERM CARE AND LONG TERM CARE FACILITIES

AN INTRODUCTION TO THE NATIONAL LONG TERM CARE SURVEYS

Robert Clark.

Office of Disability, Aging and Long Term Care Policy with the U.S. Department of Health and Human Services.

Background: A major source of nationally representative information on changes in the health and functioning of the elderly population is the National Long Term Care Surveys (NLTCS). To date, the surveys have been administered in 1982, 1984, 1989, 1994, and 1999 (although 1999 data has not yet been released). The aim of the survey is to examine demographic, health and functional status changes in the disabled elderly living in the community and in nursing homes along with the trajectory of services use and costs over time.

One of the major advantages of the NLTCS is that it is based on a list sample drawn from Medicare eligibility files making it possible to draw supplementary samples of certain subgroups (such as extremely old, race or ethnicity [African Americans, Hispanics]). Analytically, the NLTCS is unique because large samples of the very old can be obtained (N=2000). An additional advantage of the NLTCS is its ability to link the survey to Medicare service use files.

Type of Data Collected: There are several survey components; however, there are some differences by year of administration as to which components are included. The following topics represent keysurvey components.

Community Questionnaire: Condition list; Assistance with Daily Living (ADL) status (detailed questions on six ADLs); Independent Activities with Daily Living (IADL) status (detailed questions on seven IADLs); Source, type, and amount of informal help; Source, type, amount and payor for formal help; questions on range of motion and impairment (Nagi items); Activity list; Nutrition; Social activities; Alcohol consumption and smoking; Other functioning (mental, emotional, behavioral), Housing and neighborhood characteristics; Health insurance; Medical providers and prescription medicines; Cognitive functioning; and Military service, ethnicity, income, assets.

Institutional Questionnaire: Cognitive functioning; ADL status; IADL status, Admission information; Payment Source, Health Insurance, and Income and Assets.

Institutional Follow-up: Facility characteristics; Discharge status; Admission information; Payment source; Health insurance; IADL status; and Income and assets.

Informal Caregiver Survey: Caregiver name, address; Basic demographics; Relationship to sample member; Amount and kinds of help provided; Information on care provided by others; Caregiver's living situation; Caregiver's work situation; Caregiver's health and functional status; and Caregiver's income and assets.

Sample Design: The sampling frame was drawn from the Medicare Health Insurance Skeleton eligibility Write-off (HISKEW) file. The sample was stratified geographically into Long Term Care Primary Sampling Units (LTC PSU's) which were further grouped into, for example in

1982, 173 long term care strata. Procedures for administering the survey were as follows: 1) send an introductory letter to each sample person to acquaint him/her with the survey; 2) administer a short screening interview by telephone (for 70% of the cases) to delete those who had no functional limitations, who had died, or who had entered an institution; 3) send a second introductory letter to persons whose responses to the screen indicated that they had functional limitations; 4) use a control card to collect demographic information and to record all contacts with the household; 5) administer the detailed interview to persons living in the community with functional limitations; 6) interview in a later separate survey the informal caregivers of those with functional limitations.

Findings: The latest of surveys, 1994, reinterviewed 4,463 persons who were identified as chronically disabled in any prior (1982, 1984, 1989) survey, and received a community interview in 1989 and were still living. Re-interviews of 1,354 persons who received an institutional questionnaire in 1989 were conducted. Screening for disability of a new cohort of 5,000 persons who turned 65 took place between 1989 and 1994. This maintained the national representativeness of the cross-sectional sample for persons aged 65+.

INDICATORS OF QUALITY IN LONG TERM CARE FACILITIES

Jancy Kathleen Grant, RN, PhD, Marlene Reimber, R.N., M, and Judy Bannatyne, RN, MN.

Into Journal of Nursing Studies, Vol 33, No. 5, pp. 469-478.

Author's Abstract: Quality of care is of particular importance to residents of long term care facilities because of the permanency of their situation. In this study indicators of quality of care were generated from data obtained at a primary level from those most affected by care. The critical incident technique was used to identify the indicators as perceived by 52 residents, 58 significant others, and 37 nursing staff in five long term care facilities.

Background*:* In long term care facilities, the opinions of residents are particularly important because the care received affects the quality of daily life. Residents with mild or moderate impairment may have different experiences with the quality of care, which can be elicited with an appropriate method. People who are significantly involved in the everyday life of a resident provide a further source of data particularly for those who are unable to speak for themselves. The purpose of this study was a comprehensive identification of indicators of quality of nursing care as perceived by residents, significant others and nursing staff in long term care facilities.

Study Measures: Fourteen major indicators of quality of care and numerous sub-indictors were identified. These fourteen indicators are:

- Nature of the facility
- Nature of relationships
- Acknowledgment of the personhood of the resident
- Disposition of decision-making
- Judgment short substance required
- Degree and nature of surveillance
- Presence of planning and judgment about care
- Nature of communication with the health care team
- Do or assist with activities of living which residents cannot do for themselves
- Do or assist with therapeutic activities which residents cannot do them themselves
- Manner in which activities of living and therapeutic activities are carried out
- Nature of interaction with significant others
- Provision, use and attributes of resources

Findings: For the quality of care to be high, the balance should be tipped toward a positive concept of the agency as home, rather than an institution. The lack of acknowledgement was expressed by study participants as dehumanizing, patronizing, and treating them like a child. The dynamic interaction between ordinary living and requiring care was particularly apparent in the measure – "Disposition of decision making".

Discussion: The context in which indicators are used for evaluation is of crucial importance, especially in long term care facilities where a high proportion of residents are cognitively impaired and/or have a complex mix of strengths and limitations. Therefore, the advantages of in-depth assessments of quality of care in relation to randomly selected residents should be considered rather than depending solely on the more traditional screening approaches.

SATISFACTION ASSESSMENT QUESTIONNAIRE FOR REHABILITATION RESIDENTS OF SUBACUTE FACILITIES FOR COGNITIVELY INTACT NURSING FACILITY RESIDENTS

American Health Care Association.

Background*:* The American Health Care Association developed a series of Satisfaction Assessment Questionnaires (SAQ) to assist facilities in measuring customer satisfaction. SAQs are designed to identify the most important factors of quality as defined by long term care customer groups. The questionnaires are the result of a rigorous development process that includes in-person and phone interviews with customers conducted by faculty at the University of Wisconsin and nationwide polling of customers by the Gallup Organization. This process ensures that the questions on each SAQ address areas that are highly important to each of the customer groups.

Study Measures: There are three major sections of the SAQ. The first section is the Domain Survey, the second section is the Indicator Survey, and the third section is the Annual Survey.

- The Domain Survey assesses the facility and provides overall satisfaction data across general domains.
- The Indicator Survey assesses 12 different areas [e.g., independence and respect; nursing home programs, doctor's care; health care] and provides satisfaction data on more specific elements within the general domains.
- The Annual Surveys assess the general trend data on overall satisfaction with the facility, relative importance of domains, and general demographic data on respondents.

MEASURING OUTPATIENT SATISFACTION WITH LONG TERM REHABILITATION SERVICES

Diane Davis, MHA and Gillian Hobbs, BSR.

Quality Review Bulletin, June 1989, pp. 192 – 197 (QA Communiqué).

Background*:* Patient satisfaction surveys provide important information to health care providers about the quality of their care. This information is particularly useful in program planning and evaluation and in quality assurance (QA) activities. In today's consumer-oriented society, seeking patient opinion is especially important since it reassures patients that their concerns are important to their health care provider.

Researchers of this project created an operational definition of patient satisfaction that included the following dimensions of satisfaction: access to care, and care (under care is the human aspect, clinical issue, outcome, and physical environment).

Population/ Demographics: The sample size was 50 with the majority of contestants coming from Vancouver (75.6%). Fifty three point three percent of study sample were females and 46.7% males. Of particular interest is the distribution of patients' ages, with the highest percentages falling in the 20-29, 50-59, and over 60 age groups.

Study Measures: The outpatient satisfaction questionnaire had three main measures and several sub-measures. The measures are listed below:

- Access to Care
  - Waiting time for appointment
  - Signs and directions
  - Parking
  - Transportation
  - Waiting room time
  - Flexibility of clinic hours
  - Distance to clinic
- Care
  - Therapist and Staff:
    - Friendly
    - Concerned
    - Considerate
    - Interested
    - Respectful
    - Sympathetic
    - Professional
  - Clinical
    - Skill
    - Knowledge

        - Competence
        - Discretion
        - Thoroughness
        - Provision of appropriate service
        - Adequate frequency
    - Outcome
        - Perceived
        - Worthwhile services
        - Problem managed/resolved
- Physical Environment
    - Reception
    - Clean
    - Neat
    - Comfortable
    - Magazines
    - Noise
    - Refreshments
    - Treatment space and equipment
    - Privacy

Findings: There were no significant variances in the distribution of gender and for the most part, the demographic data reflected the location of the University Hospital within the square mile. The mean satisfaction scores ranged from satisfied to very satisfied. The lowest scores were in the Access to Care section. The section receiving the highest overall mean score (3.83) was the Care section. A majority of the comments were positive.

SECTION III. ELDERLY POPULATIONS

MULTIDIMENSIONAL OBSERVATION SCALE OF ELDERLY SUBJECTS (MOSES)

Edward Helmes, Kalman G. Csapo, and Judith-Ann Short.

Beaton Sarah R. and Voge Susan A. (1998). *Measurements for Long Term Care* California: SAGE Publishing, Inc. (page 151).

Description: The MOSES is a 40-item observer-rated multidimensional measure of five areas of functioning: self-care, disoriented behavior, depressed/anxious mood, irritable behavior, and withdrawn behavior. There is an eight-item subscale for each of the five areas. The tool was designed to be completed by a member of the nursing staff – including nursing assistants – in daily contact with the resident. The MOSES can be used to plan placement (Sloane & Mathew, 1991), monitor effects of relocation (Bellin, 1990), and evaluate clinical progress or the effects of treatment programs.

Psychometric Properties: The initial sample for testing the MOSES was 2,542 individuals (70% female), with an average age of 81.3 and an average length of stay of 41.7 months, who resided in 45 diverse long term care settings in Ontario, Canada. According to Travis (1988), who considered MOSES "the most complete observer-rated functional assessment tool available", the tool has strong content validity. Predictive validity was confirmed in comparisons of MOSES scores between patient groups with different discharge outcomes. MOSES scores were significantly correlated with composite scores measuring overall physical disability.

Procedure: A staff member in daily contact with the older person completes the tool by circling explicit response options for each of the 40 items. The subject need not cooperate with the assessment; therefore, the measure is unobtrusive.

Sample Item: Physical Mobility,

On most days in the past week, when getting around inside the building, the resident:

1. Walked without any assistance
2. Moved independently with mechanical assistance (for example, walked alone with a cane or walker or crutches, or propelled himself in a wheelchair)
3. Walked with the physical assistance of staff
4. Remained bedfast or chairfast (chairfast refers to residents who were moved from bed to a chair during the daytime, but otherwise were quite immobile).

Scoring: Raters choose the alternative that best describes behavior "during the daytime in the past week." Items are rated on a 4- or 5-point Likert scale with lower scores associated with higher levels of function.

SATISFACTION WITH MEDICAL CARE AMONG ELDERLY PEOPLE IN FEE-FOR-SERVICE CARE AND AN HMO

Judith D. Kasper, PhD and Gerald Riley, MSPH.

Journal of Aging and Health, 1992, Vol 4, No. 2, pp. 282-302.

Author's Abstract: This study investigates satisfaction with care among elderly Medicare beneficiaries enrolled in a health maintenance organizations (HMO) and beneficiaries in fee-for-service (FFS) care in the same geographic area. Satisfaction with two dimensions of care, access/quality and costs, are examined, to investigate differences in enrollee/FFS evaluation of these dimensions of care as well as predictors of satisfaction with care. In addition, satisfaction among healthy and chronically ill elderly people in these two care settings is explored. Results indicate higher satisfaction with access/quality of care among those in FFS and higher satisfaction with costs among HMO enrollees. These relationships hold controlling for other variables among the chronically ill elderly. Sources of variation in satisfaction are somewhat different between the HMO and FFS elderly. Satisfaction with paperwork and ease of getting to care, however, influences satisfaction with other aspects of care in both populations.

Background*:* "Patient satisfaction with medical care may reflect numerous influences, ranging from individual attributes to personal experience with medical care." There is extensive literature on satisfaction with care that predates recent interest. The literature indicates that a high percentage of people report being satisfied. However, studies of patient satisfaction among population subgroups, such as the elderly, are relatively few. This article investigates satisfaction with care among elderly Medicare beneficiaries enrolled in an HMO, and beneficiaries in Fee For Service (FFS) care in the same geographic area. Two dimensions of care (access/quality and costs) are examined to investigate differences in enrollee/FFS and predictors of satisfaction with care within the HMO and FFS groups. Additionally, satisfaction among healthy and chronically ill elderly people in these two care settings is explored.

Several authors (Aday, Fleming, Anderson, Hall, and Ware) have demonstrated, through a number of studies, that satisfaction with medical care among elderly people may be affected by individual attributes such as age or race, health status, or experience with care.

Measures: the authors in this project considered a number of measures. Descriptions of these measures include:

Patient satisfaction – evaluate aspects of patient's medical care as excellent, good, fair, or poor. Questions in this domain reflect costs of care, access to care, and provider competence, communication, and humaneness. A summary access/quality score was also formed by combining six individual items relating to access to care and provider behavior. Satisfaction with costs was determined by a single item inquiring about premiums for HMO enrollees and fees for those in FFS.

Sociodemographic characteristics – Age, education, and gender. Annual household income was obtained and categorized people into high, medium, and low-income groups.

Health status and attitudes toward health – Health status was indicated by presence or absence of Assistance with Daily Living (ADL) limitations in eating, dressing, bathing, or using the toilet that require assistance. Respondents were also asked whether they worry more about their health than others and whether they avoid going to the doctor.

Experience with medical care – Extent of contact with providers (being under care for chronic conditions, number of visits, number of months in the HMO), and experience with other aspects of obtaining care (ease of getting to a site, paperwork to file claims) that my affect satisfaction with access/quality or costs.

Findings: Nearly half of the elderly patients regardless of health care delivery setting rate their care as excellent. In evaluating professional competence and courtesy/ consideration of providers, about 70% of each group rated their provider as excellent, the highest ratings among the individual items. Regression analyses on satisfaction with access/quality of care and satisfaction with costs of care indicated that enrollment status remained a significant predictor of satisfaction controlling for potential confounding variables. FFS status was predictive of satisfaction with access/quality, and HMO status of satisfaction with costs of care. There are differences within care setting, however, in relationships of specific variables to satisfaction. Female HMO enrollees, for example, were less satisfied with care than were males. No such relationship was observed in the FFS group. Within the FFS population, Medicaid coverage was related to higher satisfaction with both access/quality and costs. There was no relationship, on the other hand, between the presence or absence of private insurance and satisfaction with care. Health status was not associated with satisfaction with care, controlling for other variables. Enrollees who said they worried more about their health than did others were more satisfied, and those who said they avoid going to the doctor were less satisfied.

Discussion: Satisfaction with care is high in both HMO and FFS. On the access/quality dimensions of their care, people in FFS care are relatively more satisfied. This study also provides support for the influence on satisfaction with care among elderly people of indicators of experience with medical care. Among elderly people in FFS care, being under treatment for a chronic condition was related to greater satisfaction with access/quality of care. The competitive advantage of HMOs for Medicare beneficiaries appears to be the reduced costs of care. One issue that could not be addressed is the effects of satisfaction among HMO enrollees, on disenrollment because these people are no longer represented in the HMO population at the time of the study's interview

The study is limited to the experience of Medicare beneficiaries in one HMO and FFS care in the surrounding geographic area. The differences by care setting in satisfaction may be related to organizational features of a group model HMO. These are among the features that allow HMOs to restrict use and thereby achieve cost savings.

SATISFACTION WITH OUTPATIENT GERIATRIC EVALUATION AND MANAGEMENT (GEM)

Lynne Morishita, MSN, Chad Boult, MD, MPH, Lisa Boult, MD, MPH, Stan Smith, MD, MPH, and James T. Pacala, MD, MS.

The Gerontologist, 1998, Vol. 38, No. 3, pp. 303-308.

Author's Abstract: The purpose of this study was to evaluate high-risk older adults' satisfaction with outpatient geriatric evaluation and management (GEM). Community-dwelling Medicare beneficiaries (n=522) age 70 years and older who had a high probability of repeated admissions to hospitals (P > .40) were randomly assigned to receive either usual care or GEM for six months. Despite the stresses imposed by outpatient GEM (e.g., new relationships with providers, frequent office visits and changes in treatments), the mean satisfaction scores of the recipients of GEM were 9% higher than those of the recipients of usual care (4.31 vs. 3.96, p <0.001). The primary physicians of GEM recipients were also highly satisfied with GEM care.

Background*:* Patient's satisfaction with health care is regarded as an indicator of quality, and quality ratings are being used increasingly by consumers and other purchasers for selecting health plans and care providers. Outpatient geriatric evaluation and management (GEM) is a sustained, intensive interdisciplinary process that begins with a comprehensive geriatric assessment (CGA) of many factors that affect health and continues until the implementation of a new plan of care has been completed.

The purpose of this study was to evaluate, among other outcomes, high-risk older adults' satisfaction with seven aspects of outpatient GEM. Because the long term effectiveness of GEM probably depends in part on primary physicians' willingness to support the care provided to their patients by GEM programs, we also explored the degree to which primary physicians were satisfied with GEM care.

Population/ Demographics: A survey was mailed to 23,801 community-dwelling Medicare beneficiaries age 70 years and older who were living in or near Ramsey County, Minnesota, and who were not enrolled in managed care plans. To be eligible for participation respondents had to have a high probability of repeated admissions to hospitals, which were calculated from eight of the survey questions. A total of 2,286 high-risk respondents were contacted by telephone to determine their eligibility and interest in participating in the study. Final enrollment in the experimental group required the verbal permission of the participant's established primary physician and the completion of at least one home visit and two clinic visits. Two hundred forty-eight participants were enrolled in the experimental group and 274 in the control group. Patients in the experimental group received a comprehensive geriatric assessment followed by primary care visits and continuous case management. Once it had been determined that the patients had reached their GEM treatment goals, they were designated as ready for discharge.

Study Measures: Participants in both study groups were sent the Patient Satisfaction Questionnaire (PSQ-18), an 18-item instrument with seven subscales measuring general satisfaction, technical quality, interpersonal manner, communication, financial aspects of care,

time with physician, and accessibility. In addition to the PSQ-18, patients in the GEM groups were also sent four statements (with Likert responses) specifically about GEM.

Findings: Most participants, including 98.8% of the control group, had established relationships with primary physicians: 7.1% had relationships with geriatricians, 30.2% with family physicians, and 59.6% with internists. The overall mean PSQ-18 score was 8.8% higher in the experimental group. The mean satisfaction ratings of the care provided by the three GEM teams were 4.37, 4.33, and 4.21 (on a scale of 1 – 4) but were not statistically significant. The mean scores on the seven subscales were more favorable in the experimental group. A higher percentage of experimental participants expressed high satisfaction with their care than did the control group with their care. To determine whether higher satisfaction with GEM was limited to participants with particular characteristics, the experimental and control groups' satisfaction ratings within subgroups were compared. In 14 of the 16 subgroups, the GEM recipients had significantly higher mean PSQ-18 scores than the controls. In response to the four statements about GEM, the experimental respondents indicated that the GEM staff had helped them to understand their health conditions, that the GEM clinic was conveniently located, the GEM staff was easy to reach by phone, and they would recommend the GEM program to others.

Discussion: Satisfaction in both the experimental and the control groups was high, but satisfaction with outpatient GEM was significantly higher. This difference occurred despite the control physician's knowledge that his patients were controls in a study of the outcomes of different models of health care. As consumer satisfaction is increasingly monitored, disseminated, and accepted as an indicator of the quality of health care, it will influence providers' and health plans' stature in the community and in the marketplace. Because satisfaction is associated with improved compliance with physicians' recommendations, improved medical outcomes may result.

THE HIERARCHICAL STRUCTURE OF GERIATRIC PATIENT SATISFACTION AN OLDER PATIENT SATISFACTION SCALE DESIGNED FOR HMOS

Arthur G. Cryns, PhD., Robert C. Nichols, PhD., Leonard A. Katz, MD., and Evan Calkins, MD.

Medical Care, August 1989, Vol. 27, No. 8, pp. 802-816.

Author's Abstract: This paper describes an instrument design effort aimed at measuring patient-satisfaction among older (65 years and over) subscribers of HMOs. The study was conducted in a multi-satellite prepaid group practice in Buffalo, New York. In order to be able to construct a satisfaction measure that would reflect the interests of the actual consumers of HMO-services, a series of four focused group interviews were held with 24 randomly selected elderly enrollees. This 60-item Older Patient Satisfaction Scale (OPSS) was submitted to a systematic sample of 279 elderly HMO subscribers. They also were asked to complete two existing OPSS-items, 14 primary factors of geriatric patient satisfaction, two second-order and one third-order general factor. The overall psychometric properties identified for the OPSS, as well as the fact that it was constructed from a healthcare consumer's perspective makes it well suited for use with a unique and rapidly expanding geriatric patient population.

Population/ Demographics: Four groups were designed to discuss the issue of patient satisfaction. The sample was divided into four separate groups, each of which participated in a 90-minute discussion of the health care they were receiving. The interviews were conducted in a nondirective fashion and were reported amid subsequently transcribed. Two different content methods were employed to analyze the interview data – analysis by topic or analysis by idea.

Study Measures: Content categories (study measures) are as follows: physicians [examples of good and bad care, indicators of quality, character of good and bad, and doctor-patient relationship]; finances [details of billing and paying, disputes; cost comparison]; appointments [keeping appointments, waiting], alternate providers [quality of alternate providers]; completeness of service, convenience of HCP [paperwork burden].

A 60-item questionnaire was constructed to be representative of the full range of the topics recorded in the focus group. Additionally, the questionnaire contained the 36-item Patient Satisfaction Questionnaire.

Findings: The responses to the 60-items constituting the OPSS scale were subjected to factor analysis. Fourteen (14) factors were extracted before estimating commonalties accounting for 61.5% of the total variance of the 60 items. Next, a second-order factor analysis was performed. The second-order factors are defined by the primary cases.

SECTION IV. CONSUMER SATISFACTION

ASSESSING THE INFLUENCE OF ADULT DAY CARE ON CLIENT SATISFACTION

Janet R. Buelow, PhD and Kendon J. Conrad, PhD.

Journal of Aging and Health, 1992, Vol. 4, pp. 303-321.

Author's Abstract: Using data collected from 74 adult care centers, this study measured various program characteristics from four different categories of respondents – clients, caregivers, staff members, and administrators. The perceptions of these respondents were examined for their associations with each other and with client satisfaction. Three program characteristics, as perceived by clients, were significantly assisted with client satisfaction (staff caring, general morale, and interior environment). The caregivers', staff members', and administrators' perceptions were not significantly associated with client satisfaction. In addition, more than these program component ratings were not significantly associated among clients, caregivers, staff members and staff advisor.

Background*:* For older persons with chronic illnesses and limited resources, dependency on the long term care system is often a necessity of life. The provision for physical survival is a basic goal of our long term care system; however, a more compassionate goal is the client's satisfaction within this system. This study addresses this goal by examining the relationship of specific program characteristics to client satisfaction in an adult day-care (ADC) program.

Study Measures: This study used four questionnaires of the Adult Day Care Assessment procedure or ADCAP. The ADCAP is a set of instruments that assess the structure, population, and process of ADC centers.

The definitions of variables in this study were of three categories: (a) perceptions of program characteristics (structure and process), and as the independent variables, (b) client satisfaction, as the dependent variable, and (c) potential confounding individual client characteristics. The client characteristics consisted of four sociodemographic variables: age, gender, marital status, and self-rated system.

The program characteristics consisted first of the structure characteristic variables – the interior environment. Additionally, the three process characteristic variables were staff caring, general morale, and communication. Finally, client satisfaction variables were adapted from the Ware Patient Satisfaction Questionnaire, and nine statements created specifically for ADC clients.

Findings: It was determined through a correlation mix that six of the eight program characteristics and three of the four client characteristics were highly correlated. The most strongly correlated client satisfaction variables were the characteristics of staff caring, general morale, and interior environment. Two program characteristics not significantly correlated with client satisfaction included communication and health services. Three of the four client characteristics were significantly correlated with client satisfaction: age, marital status, and sex.

Discussion: Three research questions were answered by this study. The first question was, "From the clients' perspective, which program characteristics of ADC centers significantly contribute to their satisfaction?". Three program characteristics – staff caring, general morale, and their interior environment – as asked by the client, related significantly to client satisfaction. The second research question asked, "If administrators', staff members', and caregiver perception of ADC program characteristics were associated with client satisfaction." Neither of these individuals was significantly associated with client satisfaction. The final research question, asked about the similarities of program characteristics ratings from all respondents. It was found that the interior environment ratings were highly correlated for administrators, staff members, and clients.

MEASURING PATIENT SATISFACTION IN PRIMARY CARE: A JOINT PROJECT OF COMMUNITY REPRESENTATIVES, CLINIC STAFF MEMBERS AND A SOCIAL SCIENTIST

Ava Biderman, Sara Carmel, and Ayala Yeheskel.

Family Practice, 1994, Vol. 11, No. 3, pp. 287-291.

Author's Abstract: We describe the process of planning and developing a questionnaire and conducting a patient satisfaction survey in a neighborhood clinic in Israel. The project was conducted by the clinic staff members, patient representatives and a medial sociologist. The satisfaction survey was conducted in patients' homes, with a 67% response rate. General satisfaction and satisfaction with specific components of service are described. Patient satisfaction was higher among men than among women, and negatively correlated with family size. The strongest predictor of general satisfaction was satisfaction with physicians' services. Implications of the survey results were decided upon by active collaboration between the clinic staff and the patient representatives. The inferences drawn from the patients' replies and the changes introduced as a result of them, are discussed. Health care consumers should be active participants in carrying out surveys of satisfaction on a regular basis.

Background*:* Patient satisfaction predicts both compliance and utilization and may even be related to improved health. It also contributes to the atmosphere prevailing in a primary care clinic. It is associated with continuity of care, the doctor's communication skills, the degree of his or her patient centeredness and the congruence between intervention desired and those received by the patient. Additional factors that may influence patients satisfaction include confidence in the health care system and a positive outlook on life in general.

Population/ Demographics: The patient population was characterized as members of the Yud-Alef Clinic and were also members of Israel's largest HMO known as Kupat Cholim (Workers' Sick Fund). The sample included 500 families (20% of the clinic's population) randomly assigned to the study from the patient register. A large number of the patients participating in the study were young families and only 8% were over 65 years old. A total of 335 questionnaires were received, 67% of the sample.

Study Measures: Satisfaction measures for the study were categories into two board categories. The categories and specific measures are:

General satisfaction measures: 1) with medical staff; 2) with administrative staff; and 3) with clinic.

Satisfaction with specific services: 1) clinic tidiness; 2) medical team's relations with patients; 3) pharmacy hours; 4) pharmacy providing medications prescribed by doctors; 5) information elicited from physicians at patients' initiative; 6) administrative staff relations with patients; 7) physician's relations with patients; 8) professional level of medical care; 9) physician's time devoted to patient; 10) appointment system; 11) referrals to specialist; 12) information elicited from nurses at patient's initiative; 13) medications prescribed by doctors; 14) family physician caring for adults and children; 15) physician's interest in personal

problems; 16) waiting time for gynecologist; 17) laboratory hours; 18) nurses' interest in personal problems; 19) clinic hours; 20) waiting time for home visits by physicians; 21) information provided by physicians at their initiative; 22) information provided by nurses at their initiative; and 23) social worker's helpfulness.

Findings: In general, satisfaction with the medical personal was higher than with the administrative staff, and satisfaction with physicians was higher than with nurses. Relatively low satisfaction was reported with the amount of information provided by doctors and nurses at their own initiative, although scores of satisfaction for information received at the patient's request were higher. Low satisfaction was reported with waiting time for a gynecologist and with waiting time for house calls. Finally, general satisfaction was strongly associated with satisfaction with physicians' services. Generally women were less satisfied than men.

Discussion: Earlier studies examined by the authors indicated that satisfaction is related to age and is strongly related to satisfaction with medical staff. The results of this study indicate associations between gender and general satisfaction with services, but in an opposite direction from that found in an earlier study where women were found to be more satisfied than men. In this study, women represented their families more often than men, a factor that could have biased these results since their satisfaction levels were generally lower.

PATIENT SATISFACTION WITH HEALTH CARE SURVEY

Linn, L.S. (1976). Patient acceptance of the family nurse practitioner. *Medical Care*, 14, 357-364.

(Information that follows on this survey was received from Behavioral Measurement Database Services, Health and Psychosocial Instruments [HaPI]).

Purpose Statement

Patient Satisfaction with Health Care Survey is a 21-item, self-administered, attitude-probing questionnaire to be completed by the patient immediately after having received medical care in an outpatient clinic or in a primary care setting. The respondent is asked to record his evaluation of treatment just received and sources of satisfaction or dissatisfaction with the experience. Some are answerable only if the patient has had care from a nurse. An additional six questions cover demographic characteristics of the respondent. Five indexes comprise the survey: (a) Index I: Access (2 items), (b) Index II: General Satisfaction With Visit (6 items), (c) Index III: Index of Rapport (2 items), (d) Index IV: Index of Satisfaction with Physician – Provider (4 items), and (e) Index V: Index of Satisfaction with Nurse – Provider (4 items). Index V "is composed of the same items as Index IV, scored in the same way, except the word nurse is substituted for doctor. Patients who receive examination or treatment from a physician answer questions comprising Index IV. Patients examined or treated by a nurse are asked to answer questions comprising Index V, and patients receiving treatment from both professionals answer both sets of questions" (Linn, p. 361).

Number of questions: 21

Directions for Scoring: Patient Satisfaction With Health Care Survey is scored using the five indexes of patient perception. The enclosed sheet provides scoring values for each item (in parentheses) by index. The values were summed all appropriate indexes and the mean scores were calculated for all patients. The higher the score, the greater the satisfaction.

PATIENT SATISFACTION WITH PRIMARY-CARE CONSULTATIONS

Grahame Feletti, David Firman, and Robert Sanson-Fisher.

Journal of Behavioral Medicine, 1986, Vol 9, No. 4, pp. 389-399.

Author's Abstract: This study examines patients' perceptions of their latest consultation with a primary-care physician. A new questionnaire measured patients' views on their "ideal" physician prior to the visit and their satisfaction on similar dimensions immediately afterward. Ratings by the 503 eligible patients (87% response rate) showed that all 43 items were relevant and that a shortened version could also be used successfully. Patients held high expectations for, but were also quite satisfied with, their physicians' actual behavior during the consultation. Factor analysis of perceptions supported other research findings and raised some anomalies in relation to over-ordering of investigations and waiting time. Other analyses showed which characteristics of physicians and patients were most influential on satisfaction and which dimensions of care were common or distinct to the 22 physicians involved in this study.

Population/ Demographics: After eliminating participants who had not met the study's specified inclusion criteria, 503 patients were eligible and agreed to complete the 43 item "ideal physician" questionnaire. Most of the patients (66%) were female, married (68%), and had completed some college (63%). The sample typically saw their own general physician (77%). Employment status among the sample was closely divided among those employed (54%) and not employed (47%).

Findings: The items in the questionnaire were originally obtained by asking 11 different community groups to describe their notion of an ideal physician. Together with a literature review on patient satisfaction, dimensions (10) were created for patients when judging the standard of care they receive from their primary-care physicians. The dimensions included: 1) competence in a physical domain; 2) competence in the emotional domain; 3) competence – social awareness; 4) the physician as a model; 5) amount of time for consultation; 6) perceived amount of continuity of care; 7) mutual understanding in the doctor-patient relationship; 8) patients' perception of their individuality; 9) information transfer; and 10) competence – physical examination.

Discussion: In general, patients appeared quite satisfied with the behavior of their physicians. Items with the highest loadings (≥ 0.6) suggested the following five main factors: 1) communication, care and reassurance; 2) professional attitudes and behaviors; 3) personal confidant of patients; 4) technical competence; and 5) generating trust in physician. Altogether, these five factors reiterated findings from recent studies of patient's satisfaction with medical care.

Completion of the 49 items required between 30 and 50 minutes. Therefore, a shortened version of the questionnaire was desirable. The shortened version, based on a collection of items most relevant to key factors, proved to be well worthwhile in terms of its economy of time and accuracy in reflecting overall satisfaction.

This study has provided clearer insights into patients' perceptions of physicians' behavior for a particular visit. It also seems clearer which general factors seem to underlie patients' satisfaction with their physicians. Finally, this study has identified which behavioral aspects are worth monitoring or screening when measuring satisfaction with particular kinds of consultation in future studies.

PATIENT EXPECTATIONS: WHAT DO PRIMARY CARE PATIENTS WANT FROM THE GP AND HOW FAR DOES MEETING EXPECTATIONS AFFECT PATIENT SATISFACTION?

Susan Williams, John Weinman, Jeremy Dale, and Stanton Newman.

Family Practice, 1995, Vol. 12, No. 2, pp. 193-201.

Author's Abstract: There is growing recognition of the importance of patients' expectations in general practice. This study aimed to investigate the types of expectations adult primary care patients have prior to consulting the GP, and how far meeting expectations is associated with increased satisfaction. Patients (n=504) attending general practitioners (n=25) at 10 London general practices were included in the study. The Patients Intentions Questionnaire (PIQ) was administered prior to the consultation to investigate patients' expectations and the Expectations Met Questionnaire (EMQ) was administered after the consultation to find out what the patient reportedly obtained. Satisfaction with the consultation was also measured using the Medical Interview Satisfaction Scale (MISS). The results of a principal components analysis of PIQ item scores indicated that the most wanted items were for "explanation of the problem". There was less desire for "support" or "tests and diagnosis". Many of the "support" items could potentially be provided to all patients, yet a proportion of patients reported not receiving these items from the GP. The results of one-way ANOVAs revealed that patients with greater numbers of their expectations met reported significantly higher satisfaction with the consultation than those with lower numbers met. The PIQ and EMQ could be potentially useful self-audit tools for use by general practitioners and trainee GPs.

Background*:* Good communication between doctors and their patients is an essential part of medical care. The doctor-patient relationship has been described as the "cornerstone of general practice" and it has been stated that the most effective and productive doctor-patient relationships in general practice occur when the doctor has a clear understanding of the patients' actual concerns as well as an accurate clinical diagnosis.

Population/ Demographics: Five hundred four adult primary care patients, attended 10 practices for a range of health-related concerns. The response rate was 84%. The age of the patient sample was 40.9 years of age. The sample was comprised of 193 males and 311 females.

Study Measures: The following measures were utilized in this study: **(1)** Expectations – measured through the Patients' Intentions Questionnaire (PIQ) which consisted of 42 statements about what patients want from the General Practitioner during the given visit, using a 3-point scale. **(2)** Meeting Expectations – measured through an adapted version of the PIQ that created the Expectations Met Questionnaire (EMQ). **(3)** Satisfaction – measured through the Medical Interview Satisfaction Scale (MISS) to assess patient satisfaction with the consultation through 26 Likert-type items with 5-point response choices.

Findings: The most important accounting for 27% of the variance was "explanation of the problem", meaning that patients wanted their GPs to explain the cause, course and prognosis of the problem. The second most important factor was "support", meaning that patients wanted

their GPs to provide general emotional support and support in relation to emotional problems. The third most important factor was "tests and diagnosis", meaning that patients wanted their GPs to refer them for appropriate medical tests and diagnostics. In general, a greater proportion of patients reported not receiving "explanation of problem" component items and "test and diagnosis" items than "support items" and the remaining PIQ items.

Discussion: The majority of patients, who wanted the GP to understand their problem and explain what was wrong, felt that these expectations along with many others were met. In the instances where GPs did not meet the expectations of the patients, it may be that GPs were unable to provide the level of information requested. When looking at meeting expectations and patients' satisfaction with the consultation the results indicate that meeting patients' expectations is significantly associated with higher rates of satisfaction. In conclusion, the findings of this study indicate that a high percentage of patients would welcome full explanations and suggests that this is a potential global need of most primary care patients, irrespective of the nature of the problem. The results also suggest that awareness by the GP of patients' expectations during consultations is vital to achieve effective communication.

REGULAR SOURCE OF PRIMARY MEDICAL CARE AND PATIENT SATISFACTION

Gregory L. Weiss, PhD and Cornelia A. Ramsey, MSPH.

Quality Review Bulletin, June 1989, pp. 180-184.

Background*:* Various studies have concluded that satisfied patients are more likely to continue using medical care services, to maintain a relationship with a specific provider, less likely to doctor-shop around, and to comply with medical regimens. Additionally, these studies have concluded that patients increasingly expect to be (and deserve to be) satisfied with care received.

Population/ Demographics: A sample of persons was selected by a modified probability-proportionate-to-size (PPS) multistage cluster sampling technique. A total of 40 persons were selected to complete a community survey.

Study Measures: Continuity of care – referring to either structural or process-oriented definitions. Structural definitions refer to ongoing care from a single provider, a team of providers, or an organization. Process-oriented definitions refer to the coordination or integration of care provided over a period of time or throughout an illness episode.

Study patients were also asked whether they always see the same physician when sick, see one of a small group of physicians who work together, attend a clinic or medical center whether a different physician may be seen on each occasion, or have no regular source of medical care.

Patient satisfaction was measured by a five-item scale constructed by Roghmann, Hengst, and Zastowny and developed through non-metric multidimensional scaling. The five-item scale measures patients' perceptions of the following items:

- Carefulness of the physician routinely seen (or for respondents without a regular source of care, for the last medical care encounter);
- Amount of concern shown by the physician;
- Willingness of the physician to listen to what the respondent says;
- Willingness of the physician to spend enough time with the patient; and
- Adequacy of the information provided by the physician.

Findings: The highest percentage of those not satisfied was recorded for respondents not having a regular source of care. The study population generally was satisfied with the physician care it received. However, important differences in overall level of satisfaction existed by source of medical care. For example, respondents who saw the same physician on each occasion had the highest average scale score. Respondents who attended a small group of physicians, or a clinical/medical center averaged a lower level of satisfaction, and respondents without a regular source of medical care had the lowest mean score.

Further, differences in patient satisfaction were statistically significant for five of the six pair comparisons. For example, patients who attended clinics where a different physician may be seen on each occasion were more satisfied than those without a regular source of care. The results were consistent with the study's hypothesis that the level of continuity in the patient/provider relationship is related to the level of patient satisfaction.

Discussion: The greater degree of continuity in the physician/patient relationship, the higher the level of patient satisfaction. This study demonstrated the importance of conceptualizing continuity on a continuum, or at least across several categories. To the extent that patient satisfaction is accepted as a worthwhile objective for the delivery of medical care, emphasis should be placed on providing the maximum feasible level of continuity.

THE IMPORTANCE OF PATIENT PREFERENCES IN THE MEASUREMENT OF HEALTH CARE SATISFACTION

Caroline K. Ross, ScD., Colette A. Steward, PhD, and James M.Sinacore, PhD.

Medical Care, 1993, Vol. 31, No. 12, pp. 1138-1149.

Author's Abstract: The idea that patients will be more satisfied with health care services that are delivered to meet their preferences is central to the concept of health care marketing. Health care providers increasingly use market segmentation and target marketing to optimize the fit between their services and the consumers who receive them. The study evaluates one model for incorporation of patient preferences into the measurement of satisfaction. Using multiple regression analysis, evaluations of three dimensions of health care satisfaction, (interpersonal care, technical quality, and access to care) accounted for 63% of the variance in overall satisfaction. Inclusion of preferences, defined, as importance ranks of each dimension, did not improve ability to predict satisfaction. Four preference segments were identified: interpersonal care seekers, access/quality seekers, access seekers and quality seekers. These four subgroups differed significantly on a number of sociodemographic, health status and health service use characteristics but no significant differences were found in satisfaction between preference segments. Patient satisfaction can best be measured as quality evaluations of dimensions without regard to preferences. In considering the merits of market segmentation and target marketing, alternative satisfaction models that link preferences to health care satisfaction or the possibility that preference targeting does not lead to greater satisfaction should be evaluated.

Background*:* Consumer satisfaction is achieved through market segmentation and target marketing. In health care, a number of market segmentation studies have been conducted to identify consumer preferences for personal physicians, hospitals, ambulatory pharmacy, HMOs, long term care insurance, and mental health care. There have been few studies in health care that have examined the relationship between preferences and satisfaction, although specific models of that relationship was not articulated. The purpose of this study was to evaluate the relationship between patient preferences and satisfaction with hospital based ambulatory care. The study will consider the linear compensatory model as the basis for the relationship between preferences and satisfaction.

Population/ Demographics: Subjects were randomly selected from those patients receiving ambulatory services at a large urban Veterans Hospital. All medicine (general and sub-specialty), surgery, dental and non-physician managed outpatient clinics were sampled. Mental health outpatient clinics were not sampled. A total of 308 patients were identified for study participation with interviews being completed with 233 subjects, resulting in a response rate of 84% for those eligible for the study.

Study Measures: Patients' Satisfaction – measured using a questionnaire based upon the Patient Satisfaction Questionnaire (PSQ). Twenty-nine items were used reflecting six dimensions of service quality (access to care, availability of services, technical quality of care, interpersonal care, communication, and financing of care). The PSQ originally was developed

using a five-point Likert response format to indicate agreement or disagreement with statements about quality of care. Ware and Hays demonstrated equivalent and in some areas better results using a five-point evaluation rating response format (poor; fair; good; very good; and excellent).

Discussion: Patient satisfaction is best measured by quality evaluations of satisfaction dimensions without regard to preferences for care. Within satisfaction dimensions, the importance of rank of dimensions and interactions between dimensions are considered as independent variables to explain overall satisfaction with care, satisfaction dimensions alone explain nearly two-thirds of the variation in overall satisfaction.

THE RELATIONSHIP BETWEEN PATIENTS' SATISFACTION WITH THEIR PHYSICIANS AND PERCEPTIONS ABOUT INTERVENTIONS THEY DESIRED AND RECEIVED

David S. Brody, MD, Suzanne M. Miller, PhD, Caryn E. Lerman, PhD., David G. Smith, MD, Carlos G. Lazaro, MS, and Mindy J. Blum, BA.

Medical Care, 1989, Vol 27, Number 11, pp. 1027-1035.

Author's Abstract: This study was designed to determine the relationship between patients' satisfaction with their physician, the types of interventions that patients reported they received, and the congruence between those interventions and the types of interventions they desired. One hundred eighteen symptomatic adult primary-care patients completed questionnaires before and after their respective medical visits. Patients who indicated they received any one of the three nontechnical interventions: education ($p < 0.001$), stress counseling ($p < 0.05$), and negotiation ($p < 0.01$), were significantly more satisfied than those who had not received these interventions. Patient perceptions about receiving technical interventions, i.e., examination, tests, medications, and nondrug therapy, were not related to patient satisfaction. The congruence between patient-intervention desires and perceptions about interventions received generally were not significantly related to satisfaction except for the interaction between receiving a medication and postvisit-medication desires ($p < 0.001$). A series of multiple regression analyses revealed that, in general, perceptions about nontechnical interventions were better predictors of patient satisfaction than perceptions about technical interventions.

Population/ Demographics: Data were collected on a total of 118 study patients at a general internal medicine clinic. Mean age of participants was 31.7 years; 62% were women, 85% were minorities, and 92% had HMO insurance.

Findings: In general, study population were satisfied with their physician. The type of interventions patients desired from physicians were evaluated before and one day after the medical visit, including their postvisit desires. Patients satisfaction with their respective physicians was measured immediately after the visit using a 10-item version of the Ware Satisfaction Scale (Patient Satisfaction Questionnaire [PSQ]). Five items related to patient's perceptions about the art of care, e.g., "the doctor seemed to have a genuine interest in me as a person"; the other five items related to the technical quality of the care, e.g., the doctor should have been more thorough in treating me." A score of 50 represented maximum satisfaction; 10 indicated minimum satisfaction.

Almost all of the study participants indicated that they were examined and educated by their physicians. However, only one third to one half of patients reported receiving any type of interventions. For those patients who did receive any of the three nontechnical interventions, they were more satisfied than those who did not receive these interventions. With respect to the intervention desires, patients seemed to desire more interventions than they initially indicated. More often than not, patients received the types of interventions they desired.

Discussion: This study suggests that the occurrence of taking a history, performing an examination, and ordering tests, as well as the alleviation of symptoms by recommending specific pharmacological and nonpharmacological therapies has only minimal impact on patients' satisfaction after a medical visit. Rather, patient satisfaction with his or her physician appears to be more directly related to the physician's efforts to deal with the patient's more personal needs. The results of this study are consistent with the findings of other studies in which patient satisfaction is related to two types of interventions that generally indicate to patients that their physician respects them as individuals and is concerned about their personal welfare, i.e., discussing the patient's ideas and discussing areas of life stress. This study, as well as others, also demonstrated the importance of providing information to patients. Finally, the results of this study also suggest that the association between satisfaction and two interventions, education and negotiation, was somewhat independent of whether the patient expressed a desire for those interventions. A possible limitation of this study is that the results of the study are based on patient perceptions about what was provided or not provided. These perceptions may not be accurate since previous research has shown that patient recall about what was said during a medical visit is far from perfect.

ABOUT THE LTC SURVEY

To learn more about how to strategically plan for the future of our long term care systems in Arizona, the Flinn Foundation funded the first state Medicaid long term care consumer satisfaction survey.

ABOUT THE EXECUTIVE SUMMARY

This series, What The Experts Say? (Literature Review) is funded by a grant from The Flinn Foundation.

This report is the first in a series of six publications. Other documents available are:

1. What The Experts Say? (Literature Review)
2. What Current Consumers Say (Survey Book)
3. Survey Data Book
4. Baby Boomers: Who Me? (Focus Groups)
5. Final Report: Now and the Next Generation
6. Trifold – Final Report Summary: Now and the Next Generation

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This report has been a joint effort of three organizations:
AHCCCS, HSAG, and Flinn Foundation.
The intent has been to define the issues and
propose viable options for policy-makers
regarding long term care in Arizona.

Additional copies can be obtained
from the AHCCCS website at
www.ahcccs.state.az.us.

Long Term Care:
Now and the Next Generation:
Final Report
Final Report Summary
Baby Boomers: Who Me?
What the Consumers Say
What the Experts Say
Survey Data Book